7.c. Medical supplies, equipment and appliances suitable for use in the home. (continued.)

- The following medical supplies and equipment are not eligible for payment:

  1) Medical supplies and equipment that are not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item determined by prevailing community standards or customary practice to be an appropriate and effective medical necessity which meets quality and timeliness standards as the most cost effective medical supply or equipment available for the medical needs of the recipient, and represents an effective and appropriate use of medical assistance funds, is within the specified service limits of the Medical Assistance program, and is personally furnished by a provider.

  2) Routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment.

  3) Durable medical equipment that will serve the same purpose as equipment already in use by the recipient.

  4) Medical supplies or equipment requiring prior authorization when prior authorization is not obtained before billing.

  5) Dental hygiene supplies and equipment.

  6) Stock orthopedic shoes.

- Medical suppliers who do not participate or accept Medicare assignment must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

7.d. Physical therapy, Occupational therapy or Speech pathology and Audiology services provided by a home health or rehabilitation agency.

- **Covered physical therapy services** are those prescribed by a physician or nurse practitioner and provided to a patient by a qualified physical therapist. When services of support personnel are utilized, there must be direct, on-site supervision by a qualified physical therapist.

- **Covered occupational therapy services** are those prescribed by a physician or nurse practitioner and provided to a patient by a qualified occupational therapist. When services of support personnel are utilized, there must be director, on-site supervision by a qualified occupational therapist.

- **Covered speech pathology and audiology services** are those diagnostic, screening, preventive or corrective services prescribed by a physician or nurse practitioner and provided by a qualified speech pathologist or a qualified audiologist in the practice of his or her profession.

- **Restorative therapy services** are covered only when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

- **Specialized maintenance therapy** is covered only when physician orders relate necessity for specialized maintenance therapy to the patient's particular disabilities.

- **Specialized maintenance therapy** is covered only when it is necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition.

8. Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every ~~60~~ 62 days.

- Except for the services identified in an Individualized Education Plan under item 13.d., private duty nursing services are not reimbursable if an enrolled home health agency is available and can adequately provide the specified level of care, or if a personal care assistant can be utilized.

- Private duty nursing services includes extended hour nursing services provided by licensed registered nurses or licensed practical nurses employed by a Medicare-certified home health agency or self-employed.

- Department prior authorization is required for all private duty nursing services. Prior authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more than 16 hours per day of private duty nursing service or up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service.

- Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home and without private duty nursing service their health and safety would be jeopardized. To receive private duty nursing services at school, the recipient or his or her responsible

8. Private duty nursing services. (continued)

party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Private duty nursing providers that are not Medicare certified must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

- Recipients may receive shared private duty nursing services, defined as nursing services provided by a private duty nurse to two recipients at the same time and in the same setting. Decisions on the selection of recipients to share private duty nursing services must be based on the ages of the recipients, compatibility, and coordination of their care needs. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program that is licensed by the state or is operated by a local school district or private school, or an adult day care that is licensed by the state.

  The provider must offer the recipient or responsible party the option of shared care. If accepted, the recipient or responsible party may withdraw participation at any time.

  The private duty nursing agency must document the following in the health service record for each recipient sharing care:

  a) authorization by the recipient or responsible party for the maximum number of shared care hours per week chosen by the recipient;

  b) authorization by the recipient or responsible party for shared service provided outside the recipient's home;

  c) authorization by the recipient or responsible party for others to receive shared care in the recipient's home;

8. Private duty nursing services. (continued)

d) revocation by the recipient or responsible party of the shared care authorization, or the shared care to be provided to others in the recipient's home, or the shared care to be provided outside the recipient's home; and

e) daily documentation of the shared care provided by each identified private duty nurse including:

1) the names of each recipient receiving shared care together;

2) the setting for the shared care, including the starting and ending times that the recipients received shared care; and

3) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of care, and scheduling and care issues.

In order to receive shared care:

a) the recipient or responsible party and the recipient's physician, in conjunction with the home health care agency, must determine:

1) whether shared care is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared care authorized as part of the overall authorization of private duty nursing services;

b) the recipient or responsible party, in conjunction with the private duty nursing agency, must approve the setting, grouping, and arrangement of shared care based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the private duty nurse, must consider and document in the recipient's health service record:

8. Private duty nursing services. (continued)

1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are appropriately and safely met;

2) the setting in which the shared private duty nursing care will be provided;

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

a) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child or foster care provider of a recipient who is under age 18;

b) private duty nursing services that are the responsibility of the foster care provider;

c) private duty nursing services when the number of foster care residents is greater than four;

8. Private duty nursing services. (continued)

d) private duty nursing services when combined with home health services, personal care services, and foster care payments, less the base rate, that exceed the total amount that public funds would pay for the recipient's care in a medical institution (This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most cost-effective, medically appropriate services.); or

e) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility.

9. Clinic services.

- A clinic that provides physician services must have at least two physicians on staff. The clinic service must be provided by or under the supervision of a physician who is a provider, except in the case of nurse-midwife services.

- A clinic that provides dental services as defined in item 10 must have at least two dentists on staff. The dental services must be provided by or under the supervision of a dentist who is a provider.

- Clinic services must be provided by a facility that is not part of a hospital or dental care, but is organized and operated to provide medical care to outpatients.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- Providers who administer ~~the~~ pediatric vaccines ~~listed~~ as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

10. Dental services.

A. Coverage of dental services is limited to medically necessary services within the scope of practice of a dentist with the following limitations:

Service	Limitation
Oral hygiene instruction	One time only.
Relines or rebase	One every three years.
Topical fluoride treatment	One every six months for a recipient 16 years of age or younger unless prior authorization is obtained.
Full mouth or panoramic x-ray	One every three years, for a recipient eight years of age or older, unless prior authorization is obtained.
Dental examination	One every six months unless an emergency requires medically necessary dental service.
Prophylaxis	One every six months.
Bitewing series	One of no more than four x-rays and no more than six periapical x-rays every 12 months unless a bitewing or periapical x-ray is medically necessary because of an emergency.
Palliative treatment	For an emergency root canal problem.

10. Dental services. (continued.)

Service	Limitation
Sealant application	One application to permanent first and second molars only and one reapplication to permanent first and second molars five years after the first application only for recipients 16 years of age and under.
Removable prostheses (includes instructions in the use and care of the prostheses and any adjustment necessary for proper fit during the first six months)	Requires prior authorization.
Root canal treatment	One root canal therapy per tooth.
Inpatient hospitalization for services	Requires prior dental authorization.
Periodontics	Requires prior authorization.
Orthodontics, except for space maintainers for second deciduous molars	Requires prior authorization.
Surgical services, except emergencies, alveolectomies, and routine tooth extractions	Requires prior authorization.
Removal of impacted teeth, unless it is an emergency	Requires prior authorization.